Caring Headlines

February 2, 2012

Taking narrative rounds on the road

sharing clinical narratives as an active learning model for inter-professional education

See story on page 4

MGH therapists, Mary Knab, PT; Karen Turner, OTR/L; and Ann Jampel, PT, engage in "fishbowl" discussion as part of Narrative Rounds exercise at recent American Physical Therapy Association conference in Clearwater, Florida.

The newsletter for Patient Care Services
Massachusetts General Hospital

Generous gift supports ethics and research programs

One such act of kindness came in the form of a generous gift from local entrepreneurs and philanthropists, the Connell family. Their donation will support two new programs: The Connell Ethics Fellowship and The Connell Nursing Research Scholars Program.

Blanche DuBois famously depended on the kindness of strangers in the play, *A Streetcar Named Desire*. Over the years, MGH has also benefited from the kindness of donors whose generosity has made it possible for us to conduct cutting-edge research, educate new clinicians, positively impact local and global communities, and provide state-of-the-art care to patients and families. One such act of kindness came in the form of a generous gift from local entrepreneurs and philanthropists, the Connell family. Their donation will support two new programs: The Connell Ethics Fellowship and The Connell Nursing Research Scholars Program.

The Connell Ethics Fellowship will prepare two experienced health professionals (one nurse and one allied health professional) to develop and refine their clinical ethics expertise. Upon completion of the program, Connell fellows will be recognized as ethics resources and play a part in addressing ethical issues through clinical ethics consultations, unit-based interventions, and committee participation.

The intensive, one-year training program, under the supervision of a clinical nurse ethicist, will provide opportunities for fellows to acquire historical, philosophical, and empirical knowledge, and provide mentoring in ethical problem-solving, consultation, and facilitation.

Connell ethics fellows will:

- participate in the clinical ethics 'life' at MGH both as learners and contributors

Jeanette Ives Erickson, RN, senior vice president for Patient Care and chief nurse

- spend 20 hours per week in mentored clinical ethics facilitation and consultation in accordance with their identified areas of interest and individual objectives
- prepare a final report summarizing their fellowship work and activities

Faculty for The Connell Ethics Fellowship will include:

- Ellen Robinson, RN, Connell Ethics Fellowship director and senior ethics faculty
- Pamela Grace, RN, senior ethics faculty
- Ruth Purtilo, PT, senior ethics faculty

Advanced practice nurses; social workers; chaplains; physical, occupational, and respiratory therapists; and speech-language pathologists with a master's degree or higher are eligible to apply for The Connell Ethics Fellowship. Applications should be sent to Ellen Robinson in the Institute for Patient Care, Founders 341, by February 15, 2012. Selections will be announced March 1st, and the fellowship will begin on March 15th.

continued on next page

The Connell's generous gift supports already robust programs in research and ethics, and we're thrilled they've chosen to advance patient- and family-centered care in this way. I urge all who are interested to apply for these exciting opportunities. For information call 4-1765 (Ethics), or 3-0431 (Nursing Research).

The Connell Nursing Research Scholars Program is designed to promote inter-disciplinary patient- and family-centered care through nursing research. Connell research scholars (novice and mid-career) will have dedicated time each week to advance their research agendas.

The selection committee will be looking for proposals that focus on the following high-priority areas:

- care of the elderly
- patient and family experience of end-of-life care
- workforce development, implementation, and evaluation
- interventions that decrease risk and improve management of hospital-acquired infections, pressure ulcers, falls, and pain
- ways to measure and evaluate care outcomes
- educational program evaluation
- advancement and evaluation of the professional practice environment (internationally)
- theoretical models that can be used to guide practice and advance nursing science
- other ideas consistent with the goals of Patient Care Services

A partial list of requirements for The Connell Nursing Research Scholars Program includes:

- a goal statement describing how the program will advance your program of research
- a statement describing your area of research
- alignment of your research with the goals of Patient Care Services and The Institute for Patient Care
- your research will play a role in advancing safe, cost-effective, patient- and family-centered care
- a demonstrated commitment to nursing research
- a statement describing the impact your research will have on clinical practice, nursing education, policy, and inter-disciplinary care models focusing on health-promotion, prevention, and quality of life
- your most current curriculum vitae

(for a complete list of application requirements, contact the Munn Center for Nursing Research at 3-0431.)

Connell research scholars will attend regularly scheduled meetings with the program advisor and/or their faculty mentor to help develop, review, and refine their research plans. And scholars will attend monthly seminars with the program advisor and other mentors.

Faculty for The Connell Nursing Research Scholars Program will include:

- a program advisor (TBA)
- Munn Faculty:
  - Dorothy Jones, RN, director of the Yvonne L. Munn Center for Nursing Research
  - Susan Lee, RN, nurse scientist
  - Diane Carroll, RN, nurse researcher

Applications should be sent to Dottie Jones at the Munn Center for Nursing Research, POB 436, by February 15, 2012. Selections will be announced, March 1st, and the fellowship will begin on March 15th.

The Connell's generous gift supports already robust programs in research and ethics, and we're thrilled they've chosen to advance patient- and family-centered care in this way. I urge all who are interested to apply for these exciting opportunities. For more information call 4-1765 (The Connell Ethics Fellowship), or 3-0431 (The Connell Nursing Research Scholars Program).

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(Cover photo Dennis Huefner)

Narrative rounds

sharing clinical narratives as an active learning model for inter-professional education

—by Ann Jampel, PT, clinical education coordinator, and Mary Knab, PT, physical therapy specialist

In October of 2011, Ann Jampel, PT, clinical education coordinator for Physical and Occupational Therapy; Mary Knab, PT, physical therapy specialist and faculty member at the MGH Institute of Health Professions; and Karen Turner, OTR/L, occupational therapist, had an opportunity to present at the American Physical Therapy Association (APTA) Educational Leadership Conference in Clearwater, Florida. Their presentation, "Narrative Rounds: a Social Construction of Knowledge through Group Reflection on Stories of Clinical Practice," addressed a unique way of understanding the role of occupational therapy and the power of clinical narratives.

Since implementation of the Clinical Recognition Program in 2002, entry- and clinician-level physical therapists at MGH have met with director of Physical and Occupational Therapy Services, Michael Sullivan, PT, to discuss their clinical narratives. Sullivan deems these discussions, "the highlight of my week." After doing this for several years, he wondered if a format could be developed that would expand the narrative experience. Over the past year, Physical and Occupational Therapy piloted a program they call Narrative Rounds in which staff present their narratives in small-group settings. Participants read their narratives aloud then 'unbundle' them with feedback from the group to gain

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At recent APTA conference, attendees have opportunity to observe and participate in Narrative Rounds.

(Photos Dennis Huefner)

greater insight into their clinical practice. Response from both departments was overwhelmingly positive.

Recognizing the value of narrative rounds, Jampel and Knab submitted a proposal to the APTA suggesting narrative rounds as an active learning model to enhance the educational experience of health professions students in the classroom.

Said Jampel, "Based on staff response to the pilot, we knew this approach was getting at something different." When surveyed, 92% of staff responding to questions about the pilot session agreed or strongly agreed that narrative rounds helped foster professional development and was a good use of their time. One respondent commented, "[I was] interested in hearing about a colleague's experience, including their internal process. We can't get that from a note or quick discussion on the unit." Another said, "It was an opportunity for two areas of practice to come together and discuss common patient challenges."

Jampel, Knab, and Turner recognized that for the writer, a clinical narrative is a retrospective learning process that allows clinicians to reflect on their practice. With the added dimension of group discussion, the learning becomes *pro*spective as staff discuss how it can be applied to future care. The narrative process also focuses more on the experience of the individual clinician compared to the kind of learning that occurs during case conferences. The recommendation was for Narrative Rounds to continue.

Reflection, commonly considered a valuable tool for healthcare practitioners, has been shown to be a key element of expert practice. The use of narratives in the Clinical Recognition Program encourages the development of reflective practice in novice clinicians. Knab and Jampel felt that academic and clinical educators could benefit from hearing how narrative rounds can help develop reflective skills in students and new clinicians.

At APTA conference in Clearwater, Florida (l-r): Mary Knab, PT; Karen Turner, OTR/L; and Ann Jampel, PT.

At the APTA conference in October, Jampel, Knab, and Turner presented theory and evidence related to the use of narratives. Said Knab, "There's a body of literature devoted to the use of narratives as a 'way of knowing' that complements traditional learning models such as case presentations."

The exercise called for participants to read a narrative written by Turner and formulate questions related to the situation described. Ten participants volunteered to be part of a 'fishbowl' discussion. They asked questions and discussed the narrative, while the other attendees observed. Turner's narrative described a patient who had undergone surgery for an aggressive brain tumor; the narrative focused on how she, as an occupational therapist, had managed his physical, cognitive, and behavioral impairments during a hospitalization of several months.

By the end of the discussion, it was clear that the unbundling process had allowed this group of physical therapy educators to experience occupational therapy practice in an entirely different way. Said one participant, "The concept of selecting the 'just-right' challenge for a patient now has a context and specificity that brings clarity to the OT role."

Said another, "Physical and Occupational Therapy don't always have the most positive relationship at my hospital. Listening to Karen talk about her work with this patient gave me insight into how OTs approach their patients and think about their needs. I'm going back tomorrow to share some of these thoughts with my colleagues."

Still another told Karen, "Your ability to successfully advocate for this patient made a huge difference in his hospital experience and outcome."

While staff at MGH have long appreciated the benefits of a narrative culture on individual practice and professional development, says Jampel, "It wasn't until we started Narrative Rounds that we discovered its power to foster inter-professional education."

With the pilot completed, Jampel and Knab are working with PT and OT leadership to begin Narrative Rounds with a slightly modified format. For more information, call 4-0128.

Neonatal transport provides valuable teaching and learning moments

As I checked in with the respiratory therapist in the Neonatal ICU, a transport request was received that changed my day. A full-term baby girl, Baby H, at an outlying hospital had been born with the umbilical cord wrapped around her neck.

My name is Leslie Smith, and I am a respiratory therapist. This narrative is one example of the endless opportunities I have at MGH to be part of a team caring for patients and teaching one another how to interact with families. On this particular day, I was the respiratory therapist in charge. I checked in with each staff member and attended the morning meeting of nursing supervisors and the senior medical resident. I'd been in the charge role for several months and knew to expect the unexpected. This day was no exception.

As I checked in with the respiratory therapist in the Neonatal ICU, a transport request was received that changed my day. A full-term baby girl, Baby H, at an outlying hospital had been born with the umbilical cord wrapped around her neck. She'd been intubated and had aspirated meconium at birth. She was in the Newborn Nursery and becoming difficult to ventilate and hemodynamically unstable.

'Katie' was the therapist covering the NICU, and she was new to pediatrics. Katie had never participated in a pediatric transport before and was eager for an opportunity to observe. I decided this would be a good chance for her to gain some experience. I sensed her trepidation when I asked her to accompany me, but she was up for the challenge. I assured her we would do everything together, and it would be a great learning experience.

Leslie Smith, RT, respiratory therapist

I arranged alternate coverage for the NICU, passed my charge-therapist duties off to one of the assistant directors, and made my way to the NICU. The transport isolette can be intimidating. It stands more than 68 inches tall and is fully stocked with everything that might be needed during transport. The ventilator is specifically designed for transport and is different from the ventilators we use in the hospital. Equipment is stored in travel bags with every pocket full, and medication pumps and a nitric oxide ventilator hang dauntingly from the sides.

Katie and I checked the equipment to make sure everything was functioning properly. The Transport Team consisted of myself, Katie, a NICU nurse, and a NICU fellow. We boarded the ambulance and headed to the referring hospital. As a team, we reviewed the case en route so we could anticipate what to expect upon arrival. I prepared Katie for what we would do. From the information the referring hospital had provided, I was concerned that the baby could have significant pulmonary hypertension, so I had made sure we

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The on-site respiratory therapist caring for Baby H seemed nervous, and I noticed she was bagging the patient at a rate suitable for adults, not infants. I had barely introduced myself when she said, "Here, take this. This is way out of my league!" and handed me the ambu bag. I told Katie to get her gloves on; she was about to get some hands-on experience.

had nitric oxide. From past experience, I knew that a full-term baby with a difference greater than 10% in saturation was indicative of pulmonary hypertension.

When we arrived at the hospital, the Newborn Nursery was a busy scene. Usually, the Transport Team receives a full report on the patient upon arrival, but there wasn't a lot of time for an in-depth exchange of information. We saw that the Baby H's oxygen saturation was 40% and her heart rate was unstable. She was mottled, pale in color, and had unilateral chest rise. Her elevated heart rate, hypoxia, and decreased breath sounds were classic signs of a pneumothorax (collapsed lung). We were told that the doctor had aspirated 30cc of air from her chest, and that she was difficult to ventilate. The on-site respiratory therapist caring for Baby H seemed nervous, and I noticed she was bagging the patient at a rate suitable for adults, not infants.

I had barely introduced myself when she said, "Here, take this. This is way out of my league!" and handed me the ambu bag. I told Katie to get her gloves on; she was about to get some hands-on experience.

The NICU nurse and I put a post-ductal oxygen saturation monitor on the baby. This allowed us to get a better indication of the degree of pulmonary hypertension. As suspected, there was a 12% difference in saturation, which indicated significant pulmonary hypertension. I quickly pointed this out to the fellow and suggested we start inhaled nitric oxide therapy, a primary therapy for persistent pulmonary hypertension in newborns. I handed Katie the ambu bag and coached her in how to effectively hand-ventilate the baby.

As Katie ventilated Baby H, I introduced the nitric oxide into the ventilator circuit and initiated nitric-oxide therapy via the ambu bag. Suspecting that the pneumothorax had re-accumulated, I listened to bilateral breath sounds and explained to Katie what I was looking for. I pointed out key vital signs and components of the physical assessment that led me to believe the pneumothorax had re-accumulated. I reinforced to Katie that she was doing a great job.

Our suspicions were correct. The pnuemothorax had collected again, and it was larger than before. The fellow began preparing for a needle aspiration. I continued to coach Katie and help her assess Baby H. Wanting her to get experience using the transport ventilator, I took over the ambu bag and talked her through the steps of getting Baby H onto the travel ventilator. The fellow aspirated more air from Baby H's chest. The team decided the best thing to do was place a chest tube.

After successful placement of the chest tube, I happened to look up and notice Baby H's father in the corner of the room watching this scene unfold—his newborn baby having a chest tube placed emergently. I walked over to Dad, introduced myself, and explained what was going on. He told me this was his first child and the whole experience was scary. I assured him we were doing everything we could to help his baby and we'd answer any questions he and his wife had before returning to MGH. I inquired about his wife, and he said she, too, was scared, not being in the NICU and not knowing what was going on.

We suggested to the father that we bring Baby H to the mother's room for a quick visit before bringing her back to MGH. Dad accompanied us as we wheeled the isolette into Mom's room. We congratulated her on her new baby girl, and she tearfully said, "I hope this isn't the last time I see her." The physician explained what was happening to their baby and gave them a picture of Baby H to keep in her absence.

We began our trip back to MGH, carefully monitoring Baby H for any change in SpO_2, heart rate, and hemodynamics. The transport went well, and we arrived back at MGH safely. Baby H continued to be unstable and was soon placed on extra-corporeal membrane oxygenation (ECMO), a treatment that uses an artificial lung and pump to support patients with acute respiratory and cardio-respiratory failure.

Baby H recovered well. Her pulmonary hypertension resolved, but she remained in the NICU for a while with mild feeding issues. Baby H was recently discharged home with Mom and Dad.

Katie thanked me for bringing her along that day. She was grateful to have had this experience, even though it was intense and intimidating for someone so new to pediatrics. And I was glad for the opportunity to share my knowledge and demonstrate my approach to challenging transport situations.

Comments by Jeanette Ives Erickson, RN, senior vice president for Patient Care and chief nurse

Life-and-death care is wrought with fear and excitement. And for a new clinician, that's magnified tenfold. Katie was fortunate to accompany Leslie, an experienced clinician, on her first neonatal transport. In this 'intense' situation, Leslie explained her clinical decision-making and actively engaged Katie in the baby's care. Leslie exquisitely role-modeled family-centered care when she brought Baby H to see Mom before returning to MGH.

Thank-you, Leslie.

Code Silver: preparing for the worst-case scenario

—submitted by Police, Security & Outside Services

These excerpts from the Code Silver training video, soon to be available on HealthStream, demonstrate the four levels of response to an encounter with an active shooter:

- Get out
- Hide out
- Call out
- Take out

Senseless acts of violence tend to stay in our memories. I'm sure, for instance, we all remember the senseless killings at Columbine High School, Edgewater Technologies in Wakefield, Virginia Tech University, and more recently, Johns Hopkins Hospital. These incidents are classified by the US Department of Homeland Security (DHS) as 'active shooter' incidents.

It is sobering to think about defending ourselves against an active shooter. And in truth, the likelihood of being involved in an active-shooter incident is as remote as being struck by lightning. But the safety and welfare of our patients and staff is the highest priority at MGH, so it makes sense to think about it, plan for it, and educate our workforce to minimize casualties should the worst-case scenario occur.

After benchmarking with DHS, outside law enforcement, and other hospitals, a procedure was developed by MGH senior leadership, Police, Security & Outside Services, Emergency Management, and Human Resources for how to respond in the event of an active-shooter incident. The response is called: Code Silver.

A three-phase roll-out plan is being implemented to train employees on what to do during a Code Silver alert. Phase I consists of training managers and supervisors; Phase II consists of training MGH employees via a video on HealthStream; and Phase III consists of a Code Silver drill to be conducted in collaboration with the Boston Police Department.

Since September, more than 100 manager/supervisor training sessions have been conducted, and Police, Security & Outside Services is finalizing the Code Silver training video.

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(Screenshots and Filming by MGH Photography)

The primary components of the Code Silver training are the four levels of response to an encounter with an active shooter:

- Get out
- Hide out
- Call out
- Take out

Getting out, or evacuating, is the first option. If there's a safe escape route, leave the premises. Have an escape route in mind; leave all belongings behind; assist others if possible. Follow the instructions of law enforcement, and do not attempt to move the wounded.

Hiding out is the second option. If evacuation is not possible, find a place to hide. The best hiding places provide protection but don't trap or restrict your ability to move. Block or lock the door if possible, hide behind large objects, and remain quiet.

Calling for help is the third option. If evacuation and hiding are not possible, remain calm and call 911. If you can't speak, leave the phone line open to allow the dispatcher to hear what's happening.

Taking the shooter out is the fourth option and should only be attempted as a last resort (if your life is in imminent danger). Then and only then, attempt to disrupt or incapacitate the shooter. Make a plan, commit to the plan, and do whatever it takes to carry out your plan.

The Code Silver training video will be available on HealthStream later this month for all clinical staff.

For more information, review the Code Silver policy in Trove. Department training can be scheduled by calling Police, Security & Outside Services at 4-3030.

Four levels of response to an encounter with an active shooter:
1) Get out 2) Hide out 3) Call out 4) Take out

New parameters for pneumococcal vaccine

The Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control (CDC) have expanded the eligibility for pneumococcal vaccine for hospitalized patients. Now, patients aged 2–64 will be offered the pneumococcal vaccine during their admission if they meet certain risk factors or diagnoses

Question: I understand there's been a change in the populations eligible for pneumococcal vaccines?

Jeanette: Yes. The Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control (CDC) have expanded the eligibility for pneumococcal vaccine for hospitalized patients. Now, patients aged 2–64 will be offered the pneumococcal vaccine during their admission if they meet certain risk factors or diagnoses, including:

- chronic heart, lung, or liver disease
- ESRD or nephrotic syndrome
- diabetes
- HIV/AIDS
- sickle cell anemia
- asplenia
- compromised immunity
- alcoholism
- smoking
- CSF leaks
- asthma

We will continue to offer the pneumococcal vaccine to patients over the age of 65.

Question: How will this be carried out?

Jeanette: POE will electronically search LMR and POE for eligible diagnoses and/or risk factors and place a standing order for patients who meet the vaccination criteria. If eMAR or LMR shows that the patient has already been vaccinated, then no standing order will be placed. As always, nurses should use their knowledge of the patient and clinical experience to help monitor and guide care.

Question: When does the additional pneumococcal screening for patients 2–64 go into effect?

Jeanette: Screening for adult patients aged 19–64 went into effect January 3, 2012; screening for pediatric patients 2–18 goes into effect later this month.

Question: How is vaccine documentation being tracked over the long term?

Jeanette: A database is being developed at the Partners level to electronically capture vaccine documentation from all Partners institutions in one repository. The database would house information for all vaccines administered to patients within the Partners network.

Question: There's been a lot of work done around influenza and pneumococcal vaccines over the past year. How has MGH done in assessing and documenting influenza and pneumococcal vaccines?

Jeanette: I'm thrilled to report that we've achieved a 100% assessment and documentation rate for both vaccines according to preliminary data from October–December, 2011. My thanks to staff for your vigilant attention to this matter, and I know our patients thank you, as well.

For more information about the new guidelines or anything to do with vaccines or vaccine documentation, call Rosemary O'Malley, RN, staff specialist, at 726-9663.

Announcements

Attention clinical research nurses

The International Association of Clinical Research Nurses (IACRN) is looking for clinical research nurses interested in participating in a new local chapter.

The IACRN is an international organization dedicated to promoting the role of clinical research nurses and providing a forum for research nurses, research nurse practitioners, and others to discuss issues common to this specialized practice.

Meetings are held three times per year. Next meeting:

March 8, 2012
6:00pm
location TBA

For more information, contact Mary Larkin, RN, at 4-8695, or e-mail bostoniacrn@gmail.com.

The MGH Blood Donor Center

The MGH Blood Donor Center is located in the lobby of the Gray-Jackson Building. The center is open for whole-blood donations:

Tuesday, Wednesday, Thursday, 7:30am – 5:30pm

Friday, 8:30am – 4:30pm

(closed Monday)

Platelet donations:

Monday, Tuesday, Wednesday, Thursday, 7:30am – 5:00pm

Friday, 8:30am – 3:00pm

Appointments are available

Call the MGH Blood Donor Center at 6-8177 to schedule an appointment.

One-stop intranet site for strategic priorities

Want to know more about the Partners-MGH patient care re-design, patient affordability, and budget review initiatives? Wondering about the time line?

To read the latest articles about this work, or if you have a cost -reduction idea or better way to deliver patient care, visit the new MGH/MGPO intranet site:

http://priorities.massgeneral.org.

Make your practice visible: submit a clinical narrative

Caring Headlines is always interested in receiving clinical narratives that highlight the exceptional care provided by clinicians throughout Patient Care Services. Make your practice visible. Submit your narrative for publication in *Caring Headlines*. All submissions should be sent via e-mail to: ssabia@partners.org. For more information, call 4-1746.

Judges Needed for Timilty Science Fair

The MGH-Timilty Partnership is looking for volunteers to judge student projects at the annual science fair.

February 6–9, 2012
8:45–11:00am
James P. Timilty Middle School in Roxbury

Volunteers may sign up for one or more days. Partners shuttles will provide round-trip transportation.

For more information, call Ellen Reavey at 617-643-6287. No prior experience necessary.

Beacon: volunteer patient-discharge and escort-request system

This past fall, inpatient units and some outpatient practices began using Beacon, the new on-line system to request volunteer assistance for inpatient discharges and outpatient escorts.

The Volunteer Department would like to share some updates on the Beacon system:

1) Effective immediately, to access the Beacon system, go to the Start Menu on your computer, go to Partners Applications, Utilities, MGH Beacon.

2) On February 1, 2012, the telephone line (6-2283) previously used to request volunteer services were de-activated. If you call 6-2283, you will be directed to the on-line Beacon system where a self-training link will be provided.

3) The self-training link (at the bottom of the screen) will provide instructions on how to use the system.

Please spread the word about the new Beacon system to avoid missed calls and potential errors in communication.

For more information about Beacon, contact Wayne Newell, manager, Volunteer Department, at 4-1753.

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Submissions

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For more information, call: 617-724-1746

Next Publication

February 16, 2012

Starting the new year with a healthy resolution

—by Jessica Saad, health educator

Meghan Baker, RD, presents "Nutrition in the New Year"

(Photo by Paul Batista)

On January 18, 2012, as part of the Healthy Living lecture series, the Maxwell & Eleanor Blum Patient and Family Learning Center kicked off the new year with a presentation by dietitian, Meghan Baker, RD, entitled, "Nutrition in the New Year." The presentation focused on the most popular New Year's resolutions of all—losing weight. Baker explained that in order to achieve any goals, lifestyle changes are necessary. And people are much more likely to be successful if they choose goals that are small and attainable.

Lifestyle changes related to losing weight might include portion-control, making healthier food choices, taking the stairs instead of the elevator, and walking more often. Joining with a friend can help motivate you. Those with a sedentary lifestyle are more likely to gain weight than those who are active. It's also important to be aware of calorie intake. Many people are unaware of the number of calories they consume. Baker pointed out that managing weight really comes down to balancing 'calories in against calories out.'

The Maxwell & Eleanor Blum Patient and Family Learning center offers a number of lecture series. All lectures are open to the public, and registration is not necessary unless otherwise specified.

For more information, call 4-7352.

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